HOSPITAL CREDENTIALS ACTION AND DUE PROCESS: A Framework For Fairness

By

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INTRODUCTION

During the past two decades, economic and social pressures have produced significant changes in the delivery of health care in the United States. Hospitals, in particular, have experienced a dramatic evolution in their responsibilities. Court rulings in the 1960s, that hospital governing bodies have the duty to monitor health care and prevent harm to patients, have received broad judicial acceptance.[1] Legislative, executive and professional recognition of this duty followed and is today evidenced by state licensure statutes, Medicare and Medicaid regulations and the standards of the Joint Commission on Accreditation of Hospitals. No longer seen as simply providing working space for physicians, hospitals are now expected to be active participants in the effort to provide only quality health care. To meet this obligation, hospitals must have a well conceived, effective system of selecting, monitoring and disciplining medical staff members. This is a function of the physician credentialing process. Adverse credentials action, usually in the form of a denial, limitation, suspension or revocation of privileges, is a critical component of hospital quality assurance.

Competing with this strong societal interest to protect the patient, is the equally compelling recognition of the right of physicians to practice their profession free from unwarranted interference. Doctors have successfully challenged adverse credentials actions on such diverse theories as tortious interference with advantageous relationships, state and federal antitrust

[1] See, Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), cert denied, 383 U.S. 946 (1966); Hellberg v. Corey, 519 P.2d 981 (Wash. 1974); Elam v. College Park Hosp., 132 Cal. App. 3d 322, 183 Cal. Rptr. 156 (1982) (a hospital must ensure quality health care by carefully selecting monitoring and continually evaluating physicians with privileges).

violations, defamation, breach of contract, intentional infliction of mental distress and violation of the Civil Rights Act.[2]

Lying directly at the point where these competing interests converge is the hospital. With its patients relying on it to protect their well being and physicians relying on having access to its facilities to practice their livelihood, the hospital cannot stray too far in favoring one concern over the other. Controversy generally arises when a hospital becomes aware that a staff physician's professional performance is suspect and adverse credentials action may be required. It is then that the delicate task of balancing these interests must be carefully undertaken. Failure to act decisively to protect the patient will subject the hospital to the risk of corporate liability for the negligent treatment provided by the physician.[3] On the other hand, if the hospital overreacts to an allegation, it may find itself losing a judgment to the aggrieved physician on one of the forementioned contract, tort or statutory causes of action.[4]

Clearly, with all that is at stake, a cogent, and professionally consistent approach to adverse credentials actions is needed. It does not exist. Despite efforts by the American Medical Association,[5] various state hospital associations,[6] and federal agencies [7] to develop procedural due process guidelines,

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[2] Chayet and Reardon, Trouble in the Medical Staff: A Practical Guide to Hospital Initiated Quality Assurance, 7 Amer. J.L. and Med. 301 (Spr. 1981)

[3] See, Darling, 211 N.E.2d 153: Elam, 183 Cal. Rptr. 156

[4] Chayet and Reardon, supra note 2

[5] Principles of Medical Ethics, Opinion and Reports of the Judicial Council of the American Medical Association (1977)

[6] E.g., California Medical Association-California Hospital Association Uniform Code of Hearing and Appeals Procedures (1971)

[7] E.g., Chief of Naval Operation (NAVOP) Instruction 6320.4 of 7Sep84

methods remain fragmented. This has the result of leaving physicians, medical staff committees and hospital governing bodies unsure of their respective rights and serves to turn what should be an unencumbered fact finding process into an event filled with bluster and confusion.

This study has been undertaken to consider practical approaches to the difficult procedural issues which arise in decredentialling cases. Part I explores the question of whether a physician is entitled to judicial review of action which is adverse to his or her existing clinical privileges. Specifically, does a physician have an enforceable right to be heard before a hospital limits, suspends or revokes his or her privileges?[8] Since the answer to this question is basic to any need to implement recommended hearing procedures, this issue is discussed at some length. Part II turns to specific trouble spots in the hearing process and attempts to meld the requirements of the law with the objectives of medical quality assurance to produce an effective fair hearing plan.

I. IS A PHYSICIAN ENTITLED TO JUDICIAL REVIEW OF A HOSPITAL DECISION TO TAKE ADVERSE CREDENTIALS ACTION?

Will a court give a physician, who has been the subject of an adverse credentials action, an opportunity to show that the hospital's decision was unjust or improper? Historically, the answer to this question has been largely determined by whether the facility was characterized as a public or private hospital; the general premise being that the internal administrative decisions of a voluntary, private organization are not subject to judicial oversight.[9]

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[8] While the focus of Part II of this study centers on credentials revocation, suspension and limitation, much of the case law and underlying philosophy is derived from situations where a physician's application for staff membership is initially denied or a hospital refuses to renew privileges. In most circumstances, there is no need to distinguish between these types of cases.

[9] Chafee, The Internal Affairs of Associations Not For Profit, 43 Harv. L. Rev. 993, 1027 (1930)

Although a number of jurisdictions have turned away from this philosophy, the distinction between public and private hospitals still may have significant impact on whether physicians may petition the courts for relief.

Private V. Public Hospitals

The fourteenth amendment to the United States Constitution provides, in part, that "no state shall deprive any person of life, liberty or property without due process of law." This protective mandate includes the right to hold specific private employment and to follow a chosen profession free from governmental interference.[10] In Board of Regents v Roth,[11] the Supreme Court considered what types of interests were included in the constitutional concepts of property and liberty.

The court began by noting that property interests are not created by the Constitution, rather, they are created and their dimensions are defined by existing rules or understandings that stem from an independent source.[12] Personal service contracts, hospital regulations and medical staff bylaws may provide this independent basis.[13] Thus, an explicit or implicit agreement between a hospital and its medical staff, that clinical privileges would only be terminated for cause, has been held to create a property interest in those privileges to which the protection of the fourteenth amendment applied.[14]

Infringement of a liberty interest under the Roth standard requires the possibility of damage to an individual's standing in a community or imposition

10 Greene v. McElroy, 360 U.S. 474 (1959)

11 408 U.S. 564 (1972)

12 Id.

13 Elbaor v Grand Prairie Hosp. Auth., 599 F. Supp. 1111 (N.D.Tex. 1984)

14 Northeast Georgia Radiology Assoc. v Tidwell, 670 F.2d 507 (5th Cir. 1982); See also, Christhilf v Annapolis Emergency Hosp. Assoc. Inc., 496 F.2d 174 (4th Cir. 1974)

of a stigma that would foreclose his or her freedom to take advantage of other employment opportunities.[15] Under this prong of Roth, denial or failure to reappoint a clinician to the staff is not a basis for a claimed deprivation of liberty if the individual remains as free as before to seek another appointment.[16] One physician contended that the rejection of his application for staff privileges created a permanent scar on his record, and was an "albatross" that would limit his liberty to pursue his profession. However, the District Court in hearing his complaint said that without a demonstration that employment opportunities had been foreclosed, it was impossible to know whether the alleged stigma resulted in a genuine deprivation of liberty.[17] Thus, the factual context in which the adverse action is taken has significant bearing on whether constitutional interests are involved.

There is little doubt that so far as public hospitals are concerned, the fourteenth amendment (or fifth amendment in the case of federally operated facilities) applies and the liberty and property interests defined by Roth will be protected by the Courts.[18] Because, the same may not be true in private hospitals, it is important to know what is public and what is private. Foremost among the decisions which have articulated the respective characteristics of public and private hospitals is Levin v. Sinai Hospital of Baltimore City.

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15 Klinge v. Lutheran Charities Ass'n of St. Louis, 523 F.2d 56, 60 (8th Cir. 1975)

16 Id.

17 Schlein V. Milford Hospital, 423 F. Supp. 541, 543, n.1 (D. Conn. 1976)

18 Peterson v. Tucson General Hospital Inc., 114 Ariz. 66 559 P.2d 186 (1976) citing, Foster v. Mobile County Hosp. Board, 398 F. 2d 227 (5th Cir. 1968); Briscoe v. Bock, 540 F.2d 392 (8th Cir. 1976)

> A public corporation is an instrumentality of the state, founded and owned by the state in the public interest, supported by public funds and governed by managers deriving their authority from the state. Public institutions such as state, county and city hospitals and asylums are owned by the public and are devoted chiefly to public purposes. On the other hand, a corporation organized by permission of the legislature supported largely by voluntary contributions and managed by officers and directors who are not representatives of the state or any political subdivision is a private corporation, although engaged in charitable work or performing duties similar to that of a public corporation.[19]

This distinction has been voiced in several jurisdictions,[20] most notably by the District of Columbia which announced what now must be considered the traditional rule in Shulman v. Washington Hospital Center.[21] Shulman confronted the controversy of a private hospital's refusal to renew a physician's appointment to its courtesy staff. After discussing Levin's public/private distinction, the District Court said

> The overwhelming weight of authority, almost approaching unanimity, is to the effect that [the power of a private hospital to appoint and remove members of its medical staff at will] exists....The action of hospital authorities in refusing to appoint a physician or surgeon to its medical staff or declining to renew an appointment that has expired or excluding any physician from practicing in the hospital is not subject to judicial review.[22]

The expressed rationale for the rule was a realization that judicial tribunals are not equipped to review the action of hospital authorities in medical staff decisions. While mindful of the fact that occasional injustice might result because

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19 186 Md. 174, 46 A. 2d 198 (1946)

20 Edson v. Griffin Hospital, 21 Conn. Sup. 55, 144 A. 2d 341 (1958); West Coast Hosp. Ass'n v. Hoare, 64 So. 2d 293 (1953); Natale v. Sisters of Mercy of Council Bluffs, 243 Iowa 582, 52 N.W. 2d 701 (1952); Weary V. Baylor Univ. Hosp, 360 S.W. 2d 895 (1962)

21 222 F. Supp. 59 (D.C., D.C. 1963)

22 Id. at 63

of personality clashes or differences of opinion, the court concluded that the courts were not in a position to substitute their judgment for that of professional groups.[23] This reasoning does not explain, however, why the court felt that public hospital staffing decisions are amenable to judicial scrutiny but private facility decisions are not. One may suspect that the distinction rests in the belief that the interests of society are best served when private organizations retain their autonomy from governmental interference.[24]

Many jurisdictions adopted Shulman's public/private distinction and its limitations on judicial review. Some states, however, did not view this dichotomy with favor. Through judicial expansion of the concept of state action, development of the theory of quasi-public hospitals, evolution of common law principles and legislative enactment, these jurisdictions reduced or eliminated the importance of the public hospital-private hospital distinction.

The Concept of State Action

The statutory mechanism most often used to protect fourteenth amendment rights from infringement by non-governmental action has been 42 U.S.C. §1983. Under this provision

> Every person who, under color of state or territorial statute, ordinance, regulation, custom or usage subjects any person within the jurisdiction of the United States or causes any such person to be subjected, to the deprivation of any rights, privileges or immunities secured by the Federal Constitution or laws, is liable to the party.[25]

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[23] Id. at 64. An exception in the Shulman decision allows judicial review where there is an allegation that the hospital failed to abide by procedural rules set forth in its constitution, bylaws or regulations. 222 F. Supp. at 64 . Other jurisdictions have followed this lead. See, Clemons v. Fairview Medical Center, 449 So. 2d 788 (1984); Bricker v. Sceva Memorial Hosp., 111 N.H. 276; 281 A. 2d 589 (1971); Berberian v. Lancaster Osteopathic Hosp. Association, Inc., 359 Pa. 257, 149 A.2d 456 (1959)

[24] Chafee, Supra note 9

[25] 42 U.S.C. § 1983

Critical to a successful application of § 1983 is the element of state action. If state action, which is synonymous with "under color of state or territorial statute,[26] is found to exist, then the decisions of a hospital will be subject to the same constitutional controls as those of any governmental entity, and the federal courts may review to ensure that due process has been provided.[27] If no state action is involved, then no § 1983 remedy is available and other authority must be found to support judicial review.

One common argument of physicians looking for review of negative credentials actions taken by non-government hospitals was rooted in the Supreme Court's Burton v. Wilmington Parking Authority holding.[28] There, the court said that a private institution's conduct was subject to the fourteenth amendment, and thus § 1983, if the state so far insinuated itself into a position of interdependence with the non-government entity that it had to be recognized as a joint participant in the challenged activity.[29] Typically, a prima facie case would be made by the plaintiff physician showing that the hospital received federal funds under the Hill-Burton Act.[30] Physicians argued that by accepting these funds and their attendant regulations, hospitals were transformed into an arm of the state. To bolster claims of government assimilation, state and

26 Doe v. Charleston Area Med. Ctr, Inc., 529 F 2d 638, 662 (4th Cir 1975)

27 Meredith v. Allen County War Memorial Hosp. Comm., 397 F 2d 33 (6th Cir. 1968)

28 365 U.S. 715, 728 (1961)

29 Id. at 862

30 42 U.S.C. § 291, (Hill-Burton provides federal funds based upon a state agencies' inventory of facilities to determine hospital construction needs and priorities under federal standards. These agencies then adopt statewide plans which are submitted to the Surgeon General of the United States or his approval. In return, a benefitting hospital incurs an obligation to treat indigent patients. Ward V. St. Anthony's Hospital, 476 F 2d 671, 674, n.5 (10th Cir. 1973).

federal tax exemptions, receipt of Medicare and Medicaid funds, state licensure and regulatory requirements and public land donations were cited.[31] This approach enjoyed some success, especially in the Fourth Circuit.[32] However the Supreme Court refined its state action analysis first in Jackson v. Metropolitan Edison Co.[33] and then in Blum v Yaretsky.[34] In Jackson the court focused its inquiry on whether a sufficiently close nexus existed between the state and the challenged action of the regulated entity so that the action of the latter might fairly be said to be that of the state. State involvement without state responsibility, the court said, cannot establish this nexus.[35]

In Blum, to avoid possible fine and/or loss of medical funds, a private nursing home transferred patients to lower levels of care in the face of government contentions that it was failing to promptly discharge patients. Justice Rehnquist, writing for the majority, pointed to three requirements for a finding of state action: (1) a sufficiently close nexus between the state and the conduct of the regulated private entity; (2) exercise of coercive power or significant encouragement by the state which led the private entity to act in the challenged matter; or (3) a private entity exercising powers that are traditionally the exclusive prerogative of the state.[36]

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31 Hodge v. Paoli Hospital, 576 F. 2d 563 (3rd in 1978); Lubin V. Crittendan Hosp. Ass'n, 713 F. 2d 414 (8th Cir. 1983); Briscoe V. Bock, 540 F. 2d 392 (8th Cir. 1976); Ward v. St. Anthony's Hospital , 476 F. 2d 671 (10th Cir. 1973)

32 Duffield v. Charleston Area Med. Ctr., Inc., 503 F. 2d 512 (4th Cir. 1974); Citta v. Delaware Valley Hosp., 313 F. Supp. 301 (E. D. Pa. 1970)

33 419 U.S. 345 (1974)

34 475 U.S. 991 (1982)

35 Jackson, at 358

36 Blum at

Applying the test, the court found that the nursing home could not be said to be acting at the behest of the government and there was no state action. As the result of Jackson and Blum, it is now accepted in every circuit that receipt of Hill-Burton funds, tax exempt status and similar government entanglement will not be adequate to support a § 1983 action.[37]

The most recent Fourth Circuit decision, Carter v. Norfolk Community Hospital Association[38] underscores the difficulty in obtaining a federal forum on the state action theory. There, a physician alleged that his revocation of clinical privileges was effected without due process. The Court of Appeals, in denying his action, found no jurisdictional basis for the § 1983 action where the hospital received Hill-Burton funds, Medicare and Medicaid funds, was subject to state and federal regulations, was exempt from state and federal taxes and received unspecified city support. A significant additional allegation was the plaintiff's claim that the hospital revoked his privileges so as to appease a Professional Standards Review Organization (PSRO) whose negative report might result in the hospital's disqualification for Medicare and Medicaid payments. The facility's concern that the PSRO would terminate these funds was viewed by the court as being indistinguishable from the nursing home's fears in Blum. Without more specific and egregious conduct by the PSRO, the hospital could not be considered to be acting for the state.

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37 Monday v. Belton, 739 F.2d 15 (1st Cir. 1984); Schlein v. Milford Hosp. Inc., 561 F.2d 42 (2nd Cir 1977); Hodge v. Paoli Mem. Hosp, 576 F.2d 563 (3d Cir. 1978); Modaber v. Culpeper Mem. Hosp., 674 F.2d 1023 (4th Cir. 1982); Greco v. Orange Mem.Hosp. Corp., 513 F.2d 873 (5th Cir) cert denied 423 U.S. 1000 (1975); Jackson v. Norton-Children's Hosp. Inc., 440 U.S. 971 (1979); Musso v. Suriname, 586 F.2d 59 (7th Cir. 1978) cert. denied 440 U.S. 971 (1979); Lubin v. Crittenden Hosp. Ass'n, 713 F.2d 414 (8th Cir. 1983); Watkins v. Mercy Med. Ctr, 520 F.2d 874 (9th Cir. 1975); Loh-Sen Yo v. Cibda Gen. Hosp., 706 F.2d 306 (10th Cir. 1983)

38 761 F.2d 970 (4th Cir. 1985)

While, as a result of these cases, state action has had only limited success in expanding judicial review of private hospital staffing actions, a somewhat different approach to the public character of private hospitals has gained wider support.

Quasi-Public Hospitals

In 1964, two New Jersey neurosurgeons formed a partnership and applied for hospital privileges at a private, non-profit hospital. The first surgeon was interviewed by the credentials committee, but after a twenty-five minute meeting, the committee recommended that his application be denied. The second surgeon was interviewed by the same committee two months later. When it became clear to the committee that this second surgeon had no interest in working in the hospital on a solo basis, without his partner, the committee recommended that his application be denied. Each applicant was later told that the reasons for denial were that the applicants were already on the staff of two other hospitals; that they lived in another town; and that the hospital already had four neurosurgeons on its staff. The applicants requested, but were denied, a hearing. They later learned that the reasons given to them for denying their applications were not true. In fact, the second applicant would have been recommended for admission to the staff had not his request for membership been bracketed with his partner. The reason for denying the first surgeon's application was because the committee had received a reference which raised questions about his personality. [39]

As a result of facts such as these, some jurisdictions began to look more closely at the role and function of hospitals and the traditional public-private facility distinction.

[39] Sussman v. Overlook Hospital Ass'n, 92 N.J. Super. 163, 222 A.2d 530 (1966)

In Shulman,[40] the District Court for the District of Columbia had concluded that the mere fact that a hospital is operated for the benefit of the public and not for profit does not destroy its character as a private institution. A private hospital is not a public utility, the court said. "Neither is the operation of the hospital a public calling such as that of a common carrier, light or power companies or a telephone company."[41] In so holding, the court placed itself squarely at philosophical odds with the New Jersey Supreme Court which earlier in 1963 decided Greisman v Newcomb Hospital[42] and formed the primary basis of dissent to the rule that the staffing decisions of a private hospital are not judicially reviewable.

In Greisman, the court confronted the validity of a hospital bylaw which had the effect of excluding osteopathic physicians from the medical staff. The plaintiff, an osteopath, had an unrestricted license from the state of New Jersey and practiced in Vineland, a small town served only by Newcomb Hospital. The hospital was a non-profit corporation which solicited and received charitable contributions and had recently completed additional construction which was funded almost entirely by public subscriptions. Relying on the same authority cited in Shulman, the hospital sought to avoid judicial intervention into its staffing policy on the grounds that it was a private hospital. Although agreeing that the hospital was a non-profit organization, the New Jersey court was struck by the fact that the hospital constituted a virtual monopoly in its geographic area. It also discussed the judicial scrutiny imposed on other private businesses and professionals which served the common good such as innkeepers, carriers

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[40] Shulman, at p. 62

[41] Id.

[42] 40 NJ 389, 192 A.2d 817 (1963)

and farriers. Hospitals, too, were being operated, not for private ends, but for public benefit, the court concluded. Therefore, the hospital's powers, particularly those relating to the selection of staff members, must be considered powers held in trust. Thus, courts would be remiss if they did not intervene where those powers were invoked for a reason unrelated to sound hospital standards.[43] The Grieisman court drew heavily upon its previous holding in Falcone v. Middlesex County Medical Society[44] in formulating its position. Falcone had held that a voluntary medical society, with a de facto monopoly over appointments to local hospital staffs, so affected economic rights of physicians in the area that it assumed a quasi-public function and judicial review of its rejection of a membership application was proper.[45]

The importance of monopoly position and economic deprivation in reviewability cases has varied in subsequent applications. In 1967 the New Jersey Superior Court, Appellate Division, heard the case of Sussman v. Overlook Hospital Association[46] in which two surgeons were denied hospital privileges without a hearing and brought an action to compel their appointment. The Chancery (trial court) Division entered extensive findings of fact in its decision ordering the hospital to formulate procedures to ensure fair review of the plaintiff's application. Implicit or explicit in those findings were conclusions that the hospital was a private (non-government) facility, that the reason for denying the clinician's application stemmed from a personality clash, that Overlook Hospital exercised no monopoly power (other hospitals served the

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43 Id at 825

44 34 N.J. 582, 170 A.2d 791 (1961)

45 ID at 800

46 95 N.J. Sup. 418, 231 A.2d 389 (1967)

area) and there was no economic deprivation to the plaintiffs (each enjoyed an otherwise successful practice).[47] Despite the significant deviation from Griesman's factual context, the Appellate Division affirmed the Chancery Court's decision. It agreed that Overlook Hospital's Board of Trustees owed a duty to the surgeons and to the public, to conduct more substantial inquiry into the applications for appointment.

Two years later, the New Jersey Supreme Court again heard a controversy involving the staffing decision of a private hospital, ordering that extensive due process rights be afforded a physician denied privileges. The court in Garrow v. Elizabeth General Hospital Dispensary,[48] citing Greisman, stated that a non-profit hospital serving the public generally is a quasi-public institution, which has a fiduciary relationship with the public arising out of its public trust.[49] Nowhere in the discussion of facts or law does the court mention monopolistic position or economic deprivation as prerequisites to judicial intervention.

As other jurisdictions critically examined the traditional non-intervention doctrine, the Greisman decision was repeatedly referenced as authority for an alternate approach. Most courts electing to follow its principles adhered to the formulated analysis of quasi-public institutions and looked for monopolistic positions or economic harm to plaintiffs before permitting judicial review. Alaska, Arizona, Hawaii and Washington have taken this stance.[50] Other

47 Sussman v. Overlook Hospital Ass'n, 92 N.J. Super 163, 222 A.2d 530 (1966)

48 79 N.J. Sup. 418, 231 A.2d 53 (1979)

49 Id at 537

50 Starrs v. Lutheran Hospital and Homes Society of America, 661 P. 2d 632 (Alas 1983); Patterson v. Tucson General Hosp. Inc., 559 P. 2d 186 (Ariz. App 1976); Silver V. Castle Memorial Hosp, 497 P. 2d 564 (Haw. 1972); Rao v. Auburn General Hosp, 517 P. 2d 240 (Wash. App. 1973)

jurisdictions have not concerned themselves with specific indicia of the quasi-public nature of an otherwise private facility. They have taken the position that a court may exercise its jurisdiction whenever a physician's staff privileges have been adversely affected by a private hospital operated to serve the general public. Colorado, Mississippi, Montana, New Hampshire and Vermont have steered this course.[51] New Mexico has recently joined the list of jurisdictions which permit review on a quasi-public theory. In an interesting application of Greisman, New Mexico's Supreme Court took the position that since so much of its territory was rural and sparsely served by hospitals, the monopolistic conditions described in Griesman were so prevalent, that permitting review of private hospitals within the jurisdicton was patently consistent with the philosophy and objectives expressed in that case.[52]

Further inroads into the traditional rule, based on quasi-public analysis, appear imminent. Several states which previously embraced Shulman have reconsidered the issue and while not making a clean break from the Shulman philosophy, sufficient ambiguity exists to question the continued viability of the doctrine in the jurisdiction. Kentucky and Indiana each have decisions which appear to have opened the courtroom door a little bit wider.[53] While the signals and inconsistencies are not so strong, courts in Kansas, Minnesota, Oregon,

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51 Hawkins v Kinsie, 540 P.2d 345 (Colo. 1975); Lloyd v. Jefferson Davis Mem. Hosp, 345 S.2d 104C (Miss. 1977); North Valley Hosp Inc v. Kauffman, 544 P.2d 1219 (Mont. 1976); Woodard v Porter Hosp Inc. 217 A.2d 37 Vt. 1966); Bricker v. Sceva Speare Mem. Hosp., 281 A.2d 589 (N.H. 1971)

52 Kelly v. St. Vincent Hosp, 692 P.2d 1350

53 McElhinney v William Booth Mem. Hosp., 544 S.W.2d 216 (Ky. 1976); cf. Hughes v Good Samaritan Hosp, 158 S.W.2d 159 (Ky. 1942); Kennedy v. St. Joseph Memorial Hosp, 482 N.E.2d 268 (Ind. 1985) cf, Yarnell v. Sisters of St. Francis Health Services, 446 N.E.2d 359 (Ind. 2983)

Pennsylvania and Rhode Island have also provided hints of a change.

It is important to realize that the quasi-public label has been applied thus far only to private non-profit hospitals. Examining Greisman and the decisions which have followed, it does not appear that the quasi-public analysis can be consistently applied to private, for profit facilities. It would seem that those institutions would be unaffected by this line of authority.

Evolution of Common Law: "Fair Procedure" in California

One year before the Greisman decision in New Jersey, the California Supreme Court recognized the danger of insulating private hospital action from judicial review. Expanding on its 1959 decision in Wyatt v Tahoe Forest Hospital District[54] (recognizing physician due process rights in public hospital staffing actions), the court rejected the suggestion that private hospitals must have absolute discretion to exclude doctors from their staffs in order to maintain professional standards and high quality medical care.[55] In 1969, the court considered Pinsker v Pacific Coast Society of Orthodontics,[56] an appeal by an orthodontist who had been denied membership in a professional society. While noting that the association was not an economic necessity, the court concluded that it still wielded monopoly power over the practice of orthodontics and affected significant economic and professional concerns. Thus it was clothed with a public interest and individuals had a judicially enforceable right to have their applications considered in a manner comporting with due process principles.

54 174 Cal. App. 2d 709, 345 P.2d 93 (1959)

55 Willis v. Santa Ana Community Hosp. Ass'n, 58 Cal.2d 806, 26 Cal. Rptr. 640, 376 P.2d 568 (1962)

56 1 Cal.3d 160, 81 Cal. Rptr. 623, 460 P.2d 495 (1969)

A second Pinsker v Pacific Coast Society of Orthodontics[57] followed with the California Supreme Court declaring that it recognized a common law right of individuals to pursue a lawful occupation free from intentional interference, either by unlawful means or by means otherwise lawful but without sufficient justification. A private association, the court said, must refrain from arbitrary action. Rather, its action must be both substantively rational and procedurally fair.[58] The court explained that this right of fair procedure could be satisfied by any one of a variety of procedures which would afford the physician a fair opportunity to present a position, including adequate notice of charges and a reasonable opportunity to respond.[59]

One year later, a San Francisco physician petitioned a court to compel a private hospital to consider his application for privileges. The Court of Appeals, drawing upon the preceding authority, ruled that regardless of monopolistic position or economic deprivation, private hospital staff privilege decisions are subject to review using the fair procedure criteria.[60]

Legislated Review

One final category of jurisdictions which have wrested themselves free of the traditional Shulman philosophy is comprised of those states which have enacted statutes governing review of medical staff decisions. New York's

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57 12 Cal. 3d 541, 116 Cal. Rptr. 245, 526 P. 2d 253 (1974) citing, Guillary v Godfrey, 134 Cal. App. 2d 628, 286 P 2d 474 (1955)

58 Id. at 252 (to avoid confusion between this common law right and constitutionally imposed rights, the Pinsker court says that it would refrain from using due process language and would instead refer to a requirement of fair procedure. 116 Cal. Rptr. at 251 note 7)

59 Id. at 255

60 Ascherman v St. Francis Mem. Hosp, 45 Cal. App. 3d 507, 119 Cal. Rptr. 507 (1975)

legislation, for example, provides that it is improper for the governing body of a hospital to refuse to act on an application or to deny or expel a physician from staff membership without giving reasons. A physician who feels aggrieved may file a complaint with the state public health counsel and thereby initiate an investigation into the action taken.[61] This provision was designed and intended to protect the rights of physicians in privately or publicly owned facilities and to provide them some degree of due process.[62] Injunctive relief may also be available.[63]

The Virginia Health Code declares it to be an improper practice for the governing body of a hospital with 25 beds or more and which is required by state law to be licensed, to fail to act on an application, deny staff membership or to exclude, expel, curtail or terminate a physician's hospital privileges without stating the reasons therefore. Further, it is an improper practice if the adverse action is based on reasons unrelated to standards of patient care, patient welfare or other specified legitimate considerations. This provision enables an aggrieved physician, in addition to other available remedies, to seek an injunction prohibiting further violation of the section.[64]

The Florida legislature is even more protective of physician rights. The Hospital Licensing and Regulation Code stipulates that a licensed facility, having reasonable belief that a physician has engaged in conduct which constitutes grounds for discipline (as outlined in the statute) may suspend, deny, revoke or curtail the physician's staff privileges provided its procedures comply with

61 N.Y. Public Health Law, § 2801-b (McKinney 1985)

62 Fried v Straussman, 82 Misc 2d 121, 369 N.Y. S 2d 591 (1975)

63 N.Y. Public Health Law, § 2801-C (McKinney 1985)

64 Va. Health Code, § 32.1-134.1 (1979)

the standards outlined by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association, the Accreditation Association for Ambulatory Health Care and the Medicare/Medicaid Conditions of Participation.[65] This statutory intersection with professional association fair hearing guidelines introduces some of the extrajudicial pressures on facilities to provide notice and an opportunity to be heard.

Potentially, the Medicare Conditions of Participation,[66] which have significant economic impact on health care facilities, could dictate due process policy. To date, however, federal regulations on the subject have confined themselves to broad, general statements of policy regarding staff qualification and appointments. The Joint Commission on Accreditation of Hospitals also wields potentially significant economic power over health care facilities through its inspection and accreditation function and may directly impact on facility prestige and medical training program participation. In its Accreditation Manual, the Commission's Medical Staff standard requires that the medical staff adopt bylaws providing for the establishment of a fair hearing and appellate review mechanism for providers involved in adverse actions. These mechanisms must specify matters such as right to introduce witnesses or evidence, the role, if any, of legal counsel and the period of time beyond which the right to request a hearing is waived.[67] As noted earlier, even those jurisdictions which follow the traditional Shulman rule will review a private facility's action where it is alleged that the hospital failed to comply with its own bylaws or regulations.

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[65] Fla Stat. Ann § 395.0115 (1985)

[66] 42 C.F.R. § 405.1023 (1985)

[67] Accreditation Manual for Hospitals, Joint Commission for Accreditation of Hospitals (1985 edition)

Thus, in order to protect its position in the profesional community, a hospital may adopt bylaws or regulations establishing notice and hearing rights. They will then have their staffing decisions subject to judicial review, at least on the issue of whether they complied with those bylaws and regulations.

Scope and Standard of Review

Simply having a right to judicial review of credentials action will not guarantee adequate protection of physician rights in all situations. If the scope of review is too narrow or if the standards of review are not stringent, the physician may not have the opportunity to contest important issues.

When a physician is claiming that the procedure used by the hospital was not fair, the standard of review would seem clear. Since the court is rendering a decision on an issue of law which the hospital did not decide, it is a forum of first impression.[68] The issue then becomes: what process is due? This question is answered by examining whether the facility is public, so that constitutional due process principles control, or, whether it is private. If it is private and the jurisdiction follows the traditional, Shulman approach, the court will only look to see whether the hospital has followed its own bylaws, rules and regulations. If the jurisdiction has adopted a quasi-public approach, then the due process rights may be quite extensive, as in New Jersey where prehearing discovery rights and right to counsel at hearings have been recognized.[69] California, in its case law, has outlined its fair procedure

[68] Note: Denial of Hospital Staff Privileges: Hearing and Judicial Review, 56 Iowa L. Rev. 1356 (1971)

[69] Garrow v Elizabeth Gen Hosp. and Dispensary, 79 N.J. 549, 401 A. 2d 533 (1979)

requirements,[70] and those states which have legislated review will have their standards.[71]

A physician might also dispute the basis for a hospital's adverse credentials action. Now the question becomes one of whether the court will actively scrutinize the underlying reason and evidence supporting the action or whether it will merely review for abuse of discretion? In many jurisdictions, only a limited review is permitted, generally confined to an examination of whether the hospitals actions were arbitrary, capricious or unreasonable.[72] In these courts, the inquiry focuses on whether the stated reason for the action is supported by substantial evidence and whether the reason bears some relation to the legitimate interests of the hospital. Patient care would obviously be such an interest. Failure to carry required malpractice insurance,[73] and creating a disruptive environment in the hospital[74] have been upheld as valid reasons for action. On the other hand failure to meet a hospital bylaw's requirement of membership in a county medical society and graduation from a medical school recognized by the American Medical Association was not a valid basis for denying an application for staff membership in New Jersey.[75] Other jurisdictions may offer extensive review. In California, a qualified physician's right to use a

[70] See e.g, Anton v San Antonio Community Hosp., 19 Cal. 3d 814, 140 Cal. Rptr. 442, 567 P.2d 1162 (1977)

[71] See, Supra notes 61-65

[72] See, Peterson, 559 P.2d 186; Hawkins, 540 P.2d 345; Silver, 497 P. 2d 564; Lloyd, 345 So.2d 1046: Bricker, 281 A.2d 589; Kelly, 692 P. 2d 1350, Rao, 517 P. 2d 240; and Woodard, 217 A.2d 37

[73] Kelly, 692 P. 2d 1350

[74] Bricker, 281 A.2d 589

[75] Greisman, 192 A.2d 817

hospital is considered to be a fundamental interest.[76] In reviewing an action which affects such an interest, a court will exercise its independent judgment. It will examine the action taken and the factual basis for the action. If it concludes that the sanction is not supported by the weight of evidence, it must find an abuse of discretion.[77] Therefore, California's courts may substitute their own judgment for that of the hospital.

Conclusion

A physician's right to judicial review of adverse credentials action is not absolute, but it is pervasive. Public hospitals, including those few which may be so defined because of significant state action, must provide a constitutional measure of due process when affecting constitutional property or liberty interests. The federal courts may be used to ensure compliance. Private hospitals, in jurisdictions which have adopted a quasi-public theory, must provide process which can meet the standard and scope of review within their jurisdiction. California facilities must measure up to the specifications of the right to "fair procedure." Those states which have legislated a process of credentials action and review will require that their facilities comport with the statutory standards. And finally, because of professional pressures, even those private facilities which might otherwise not be subject to review, might be compelled to impose regulations and bylaws controlling actions and thus open themselves to oversight by the courts.

Even if there were no legal requirements or judicial review, objectives and methods of medical quality assurance and the inherent nature of the practice

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[76] Anton, 567 P. 2d 1162 (in determining whether a right is fundamental, economic aspects are not the sole criteria. The importance of the right to the individual in the context of his or her life must also be considered. 567 P. 2d at 1173)

[77] Id. at 1173-4

of medicine would require a fair hearing process. Seldom in the application of the art and science of medicine is a physician's action both clearly inexcusable and absolutely unpardonable. Extenuating and mitigating circumstances will abound. The active participation of objective physicians to review errors and foibles is critical. If reputations and livelihoods are destroyed by a system which operates on an ex-parte basis, regardless of the good faith of hospital boards, it won't be long before clinicians will be loath to participate lest they perpetuate a process which may some day trample them.

Thus fair hearings are necessary in all cases where adverse credentials action is contemplated. Whether the compelling factor is awareness that a decision will be subject to judicial review, or that a fair hearing plan is required by accrediting bodies, or is founded on the knowledge that an effective quality assurance program needs such hearings, the ultimate objective is the same: to balance the public's right to the best possible care with the interests of physicians in pursuing their profession free from unwarranted intrusion. Having reached that conclusion, the next question is: What is required for a fair hearing?

II. FAIR HEARING PLAN GUIDELINES

The Supreme Court's less than definitive guidance on how to determine how much process is due is yet another three-part test. This approach announced in Mathews v Eldridge[78] requires examination of: (1) the individual interest affected; (2) the risks of erroneous deprivation of that interest through use of the selected procedure, and (3) the burden on the government (or in our context, the hospital) if more extensive procedures were used. Under these

[78] 424 U.S. 319 (1975)

criteria, acceptable procedure will depend on the particular circumstances of the parties.[79]

Applying Mathews to credentials cases, the hospital's interests in maintaining quality control while avoiding a protracted proceeding which ties up its health care resources is balanced against the physician's interests in continuing a professional practice in the facility. Counterweights to each side are provided by the public's interest in the hospital's quality control, the public's interest in seeing that the hospital's services remain available to those in need[80] and the public's interest in having the physician of choice provide treatment in the facility of choice. Examining these interests and the conclusions courts have reached in evaluating credentials controversies can lead to certain basic principles of fair and objective process. The following recommendations are offered as guidelines for designing such a process. Because of factual and to some extent jurisdictional variations, they cannot be considered minimum standards or mandatory requirements. They do however, provide a framework from which to construct a fair hearing plan.

Guideline 1: Medical staff bylaws must put physicians on notice of required qualifications, performance and behavior.

Broad discretion is given to hospitals in setting medical staff standards. The widely quoted judicial philosophy is

> No court should substitute its evaluation of such matters for that of the Hospital Board. It is the Board, not the court, which is charged with the responsibility of providing a competent staff of doctors...The court is charged with the narrow responsibility of assuring that the qualifications imposed by the Board are reasonably related to the operation of the hospital and fairly administered.[81]

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79 Cafeteria and Restaurant Workers v McElroy, 367 U.S. 886, 895 (1975)

80 Silver, 497 P. 2d 564

81 Sosa v Bd of Mgrs. of Val Verde Mem. Hosp, 437 F. 2d 173 (5th Cir. 1971)

Nonetheless, exclusion from a hospital cannot rest upon a decision or rule which is substantively capricious or contrary to public policy.[82] It must reasonably relate to furthering the health care mission of the hospital.[83]

Detailed descriptions of prohibited conduct are not required and are probably not desirable given the rapidly shifting standards of medical care.[84] While courts have differed as to how general a standard may be before it is impermissibly vague, recent cases have followed the thinking that bylaws cannot be minutely codified and great latitude must be given to hospitals to prescribe their staff qualifications.[85] Some definite guidelines are appropriate, however. Disqualification on grounds of incompetence, drug or intoxicant abuse, mental or physical impairment which may adversely affect patient care, a finding of liability by a court of competent jurisdiction for medical negligence or malpractice involving negligent conduct and failure to comply with the policies, procedures or directives of the risk management program or any quality assurance committees of the hospital have been properly and specifically enumerated.[86]

One bylaw provision which has seen more than its share of litigation is that which requires a provider to refrain from disruptive conduct in the hospital. Contrary to what may be popular belief, such regulations, if (and this is an important if) constructed in terms of protecting patients and

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[82] Pinsker, 526 P. 2d 253

[83] Berryman v Valley Hospital, 196 N.J. Super. 359, 482 A.2d 944 (1984)

[84] North Broward Hospital District v Mizell, 148 So.2d 1 (Fla. 1962)

[85] See, e.g. Sosa, 437 F. 2d 173

[86] FLA. STAT. ANN. § 395.0115 (1985)

maintaining quality of care, have been overwhelmingly accepted by the courts.[87] The reasoning has been that a hospital has an interest in making sure that the physicians on staff possess the ability to work well with other staff members.[88] For example, staff conferences to review the work done in the hospital may supplement individual consultation and advice and the valuable experience gained from hospital practice. Thus, considerations of team spirit and cooperativeness can be as important as technical skills.[89] On the other hand, there is the danger that action based on personality, temperamental suitability and propensity to disrupt staff harmony is so ambiguous that it might be used as a subterfuge to mask factors having no relevancy to the issue of fitness for staff membership.[90] In addition, there may be a distinction between the ability to work with others and the ability to get along with others. The California Supreme Court addressed the difference in Miller v Eisenhower Medical Center[91] saying that the ability to work with others focuses on the ability to cooperate in the performance of hospital functions while a previously invalidated bylaw requiring staff to "get along with others"[92] focused on general compatibiity. Although accepting the "ability to work with" requirement, the court required that adverse action based on such a bylaw be predicated

87 Sussman, 222 A.2d 530; Anderson v. Bd of Trustees of Caro Community Hosp. Inc., 159 N.W. 2d 347 (Mich. App. 1968); Peterson, 559 P. 2d 186; Gilbert v Johnson, 419 F. Supp. 859 (N.D. Ga. 1976); Bricker, 281 A.2d 589; Rao, 573 P. 2d 834

88 See, McMillan v Anchorage Community Hosp., 646 P. 2d 857 (Ala 1982)

89 Note: Hospital Staff Privileges: The Need for Legislation, 17 Stanford L. Rev. 900 (1965)

90 Sussman, 222 A.2d 530

91 Miller v Eisenhower Medical Ctr., 27 Cal. 3d 614, 166 Cal. Rptr 826, 614 P. 2d 258

92 Rosner v. Eden Township Hosp. Dist., 58 Cal. 2d 592, 25 Cal. Rptr. 551, 375 P.2d 431

on a showing that the applicant's inability to work with others would present a real and substantial danger to patient care.[93] Other jurisdictions share this concern.[94] To be reasonably secure therefore, this type of bylaw should (1) require a connection between the disruptive conduct and patient care; and (2) the record should clearly and persuasively indicate that the disharmony which led to the credentials actions probably would or did have an effect on patient care and was not merely annoying to other staff and administrators.

Guideline 2: A physician must be given adequate notice of the hearing and a statement of reasons for the adverse action.

While the requirements of due process are flexible, a physician is entitled to reasonable notice of the charges and a fair opportunity to be heard with respect to those charges.[95] Conducting a hearing without adequate notice and a statement of reasons is not only tantamount to no hearing at all but undermines objective fact finding. The physician must be prepared to meet the charges and counter with available, meaningful information. The hearing body must have a firm grasp of what the focus of inquiry is so that it may channel its efforts toward resolving those specific matters. Collateral problems or trouble spots, which might adversely affect the quality of care at the hospital, may be identified. In balancing the respective interests of the physician and the facility both sides are benefitted by ensuring that the qualifications or behavior at issue are well defined.

The maximum length of time required for a physician to prepare for the hearing will vary according to the complexity of the allegations. There

93 Miller, 166 Cal. Rptr. at 835

94 Sussman, 231 A.2d 389; McMillan, 646 P.2d 857

95 Christhilf, 496 F.2d 174; Klinge, 523 F.2d 51; Anton, 567 P.2d 1162

is no reason for the bylaws not to establish a period during which the hearing must convene, for example, seven to ten days after delivery of charges and notice to the clinician. When the hearing convenes, if the physician claims not to have been able to prepare adequately, the hearing committee may (within its discretion) continue the matter for a reasonable period. It is important that this discretionary authority be discussed and guidance for its exercise included in the medical staff bylaws.

The statement setting forth the basis of the action need not be absolutely specific. There is a danger in being too precise, with the result that the committee will lack the flexibility to look into all issues which may be raised during the hearing. If the committee goes too far astray from the noticed basis of action, it leaves the physician unprepared to meet the allegations and renders any adverse decision vulnerable to attack as being arbitrary.[96] Where specific patient cases are involved and will be discussed, reference to the cases should be made.[97] The same is true when specific incidents are known which call into question the physician's qualifications. Under most circumstances it will be sufficient to use specific cases and incidents of which the physician is given notice to support general grounds for discipline such as lack of surgical judgment, lack of adequate training and background etc. One announced test is whether the nature of the fault, though generally expressed, should be understood by one with the professional training and background of the subject physician.[98]

Discovery may be important to the question of whether adequate notice has been given. Fundamental fairness requires that the physician have access

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[96] Christhilf, 496 F. 2d 174; Bock v John C. Lincoln Hosp., 145 Ariz. 432, 702 P. 2d 253)1985)

[97] Woodbury, 447 F. 2d 839

[98] Id.

to the evidence.[99] If specific patient cases are to be the topics of discussion then it is necesary for the clinician to have the opportunity to review those records. The doctor must be afforded the opportunity to defend by contesting the merits of each charge or incident.[100] It is not required that the physician be given access to the entire file of the investigatory body but there should be access to those matters which are necessary to alert him or her to the issues to be addressed.[101] If, during the course of the hearing, it becomes necessary to inquire into documents or information not previously provided, then that material can be disclosed and an opportunity given to the physician to examine and prepare a response.

Administrators often are concerned that disclosure of some information which has been received will impede the ability to investigate a doctor's temperament and competence. Courts, however, may be inclined to view the deleterious effect that nondisclosure has on the physician as outweighing the interests of confidentiality.[102] In certain circumstances the solution may be to give the information but not the source. This will suffice where it is the substance of the information which is material but the source is irrelevant. For example, a staff doctor might criticize the surgical technique of a colleague, thus raising the issue, but the hearing body judges the technique relying on medical literature and other witnesses to determine satisfactory

[99] Bock, 702 P.2d 253

[100] Christhilf, 496 F.2d 174

[101] Garrow, 401 A.2d 533

[102] Id.

methodology.[103] Several states have codified confidentiality concerns [104] and/or recognized a right of qualified privilege for witnesses in credentials cases.[105] In any event, it is unlikely that a facility will be able to take final adverse action against a physician while withholding important information. This is true even when the hospital maintains that nondisclosure is important to its peer review function.

Guideline 3: It is the duty of the hospital to provide a fair, objective hearing body.

A fair trial in a fair tribunal is a basic requirement of due process.[106] This principle applies to administrative decisions which must comply with due process requirements.[107] The objective is to have a panel that does not harbor a state of mind which would preclude a fair hearing.[108]

As a starting point, it may be easiest to discuss what the concept of impartiality does not require. It does not require that the subject physician be allowed to participate in the selection of the hearing committee members.[109] Nor does it require that the individuals on the hearing panel be completely

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103 Id.

104 See e.g., N.Y. Education Law, § 6527 (McKinney 1985); FLA. STAT. ANN. § 768.40 (1985)

105 Garrow, 401 A.2d 533

106 Goldberg v Kelly, 497 U.S. 254 (1970)

107 Gibson v Berryhill, 411 U.S. 564 (1973)

108 Laskow v Valley Presbyterian Hosp., 225 Cal. Rptr. 605 (Cal. App 2 Dist. 1986) (physician not given reasonable opportunity to inquire into credentials committee members financial relationship with department chairman and hospital)

109 See, Smith v Vallejo General Hosp., 170 Cal. App. 3d 453, 216 Cal. Rptr. 189 (1985) and Anton, 567 P.2d 1162

unfamiliar with the physician or the underlying facts.[110] Disqualification should occur when a panel member has an actual bias in the matter. Disqualification is also appropriate when "a situation exists under which human experience teaches that the probability of actual bias is too high to be constitutionally tolerable."[111] Therefore, partiality problems should be examined from two perspectives, individual and institutional.

From the individual vantage point, hearing committee members should be disqualified if they have a prejudgment concerning issues of fact about the case or if they have some partiality which evidences bias or personal prejudice.[112] An established position or belief on issues of policy (e.g. physicians who have abuse controlled substances should have privileges revoked regardless of successful rehabilitation efforts) need not be disqualified.[113] Members who stand to gain or lose some interest as a result of the decision should be disqualified.[114] For example, the medical staff of any hospital has a pecuniary interest in the number of doctors on the staff. However, bad motive is not to be presumed.[115]

Involvement in the preliminary procedures required to bring the case to a hearing is not necessarily equivalent to unacceptable bias or familiarity. Thus where one member of a credentials committee assisted the hospital

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110 Withrow v Larkin, 421 U.S. 35 (1975); Ritter v Bd of Commissioners of Adams County, 637 P 2d 940 (Wash. 1981); Suckle v Madison General Hosp., 499 F 2d 1364 (8th Cir. 1974) (hearing offered to plaintiff before hospital's entire active medical staff was not inherently deficient)

111 Laska, 225 Cal Rptr at 608

112 See, e.g., Withrow, 42 1 U.S. 35

113 Id.

114 Id.

115 Richards v Emanual County Hosp. Auth., 603 F. Supp 84 (S.D. Ga. 1984)

attorney who was drafting charges by interpreting for him a memo received from the Director of Nurses, disqualifying activity was not found to exist.[116]

In order to establish partiality or other disqualifying factor, the clinician should be provided an opportunity to question committee members.[117] This questioning should be strictly limited, under procedures prescribed in the bylaws to issues of bias. The physician need not be given the opportunity to "try the judges" by questioning their professional performance or their compliance with bylaws unless it directly impacts on the question of impartiality.[118]

Institutional impartiality raises more difficult questions. Here the issue is whether the facility taints its committee members because of the way it has structured its credentials review process. Before a decision can be made in a credentials case, an investigation into the allegations must usually be conducted. When the investigation is carried out by one body, such as, the credentials committee, and its recommendation forwarded for a hearing and decision by a separate body, such as the Executive Committee of the Medical Staff, then, provided there is no overlapping of membership, there is no institutional partiality. Many times, however, the investigative body and hearing body are the same or there is an overlap of membership. How does the law view this arrangement? The answer seems to be that there is one rule for California and one rule for everyone else. Taking the latter first, the Supreme Court of the United States has written that "the incredible variety of administrative mechanisms in this country will not yield to any single organizing prniciple."[119] Therefore, "it is not surprising to find that the case law, both federal and state, rejects the idea that the combination of judging and

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116 Ladenheim v Union County Hosp. District, 31 Ill. Dec 568, 76 Ill. App. 3d 90, 394 N.E. 2d 770 (1979)

117 Laske, 225 Cal.Rptr.at 608

118 Woodbury. 447 F.2d 839

119 Withrow, 421 U.S. at 1467

federal and state, rejects the idea that the combination of judging and investigative functions is a denial of due process."[120] Any contention that the combination of these functions has created an unconstitutional risk of bias in administrative adjudications has a difficult burden of persuasion and must overcome a presumption of the honesty of adjudicators.[121] An example of the application of this philosophy might be helpful.

In Duffield v Charleston Area Medical Center,[122] the Fourth Circuit was hearing the appeal of a surgeon whose privileges had been revoked. Procedurally, the chairman of the hospital's surgery department had recommended to the Board of Governors that the revocation take place. The Board reviewed, accepted and adopted the recommendation, subject to the surgeon's right to a hearing before a Joint Conference Committee on which several Board members also sat. It was the position of the surgeon that the members of the governing board who sat on the Joint Conference Committee had, by their action of accepting and adopting the recommendation of the Department of Surgery, made a prejudgment of the case and therefore were disqualified to sit or vote on the Joint Conference Committee. In rejecting this argument the court reviewed established case law concluding that (in the judicial context) the bias and familiarity which serves as a disqualifier must stem from an extrajudicial source. In other words, the opinion on the merits was developed on some basis other than what was learned from direct paticipation.[123] Noting that application of this rule extended to administrative

[120] Id., citing 2 K. Davis, Administrative Law Treatise § 1302 (1951)

[121] Withrow, 421 U.S. at 1464

[122] Duffield, 503 F.2d 512

[123] U.S. v Grinell Co., 384 U.S. 563, 568 (196)

bodies,[124] the court concluded that the situation in which the members of the board and Joint Conference Committee found themselves was analagous to a judge issuing a show cause order in connection with an application for preliminary injunction. Thus, absent a showing of actual bias, disqualification was not required.[125]

At least one court has applied a "Rule of Necessity" to situations where institutional bias is at issue.[126] Application of the rule begins with the premise that due process in hospital cases dictates that physician problems be resolved with a minimum of procedural complications due to the hospital's interest in patient safety.[127] It then continues: "Because only the hospital board has the power to revoke hospital privileges, the policy favoring an unprejudiced tribunal must yield to allow action by the only body empowered to act in the matter...Disqualification will not be permitted to destroy the ~~openly~~ only tribunal with power in the premises.[128] If this approach seems to overly patronize the hospital's interest, California has shown leanings the other way.

In its Anton v San Antonio Community Hospital[129] decision the California Supreme Court took a liberal but not radical stand on the question of impartiality when it ruled that minimal due process required a fair hearing by a committee

124 NLRB v Donnelly Co., 330 U.S. 219 (1947)

125 Duffield, 503 F. 2d at 519

126 Leonard v Board of Directors, Prowers City Hosp. District, 673 P. 2d 1019, (Colo. App. 1983)

127 Id., citing, Board of MEdical Examiners v Steward, 203 Md. 574, 102 A.2d 148 (1954) and Schwab v Ariyoshi, 57 Haw. 348, 555 P. 2d 1329 (1976)

128 Duffield, 503 F. 2d at 519, citing, Stretton v Wadsworth Veterans Hosp., 537 F. 2d 361 (9th Cir. 1976)

129 Anton, 567 P. 2d 1162

whose members were not previously involved in the proceeding. Subsequent to Anton, a case was decided by the California Court of Appeals which was expected to send a "reverberating shock wave throughout the entire medical community."[130] While such a shake-up has so far failed to materialize, Applebaum v Board of Directors of Barton Memorial Hospital[131] has created uncertainty and some apprehension among hospital administrators. Because of its potential, a detailed discussion of the case follows.

In 1977, Dr. Furman, one of two board certified obstetricians on the staff of Barton Memorial Hospital, a South Lake Tahoe facility, wrote to the hospital's chief of staff transmitting nursing complaints about Dr. Applebaum's delivery techniques and requesting an investigation pursuant to the hospital's bylaws. Applebaum, a board certified family practitioner, had practiced at the hospital for three years. Dr. Furman included in his letter allegations of incompetence in the performance of deliveries and care of the newborn, unauthorized use of experimental drugs, falsification of medical records and other improprieties. Dr. Furman and the other board certified obstetrician were members of the hospital executive committee which met and appointed an ad hoc committee consisting of six physicians, including the two obstetricians and two pediatricians to investigate the charges. This committee considered Dr. Furman's letter and letters from the nurses who originally brought the matter to light and discussed several patient records. After deliberating, the ad hoc committee recommended to the executive committee that Dr. Applebaum's obstetrical privileges be suspended. The executive committee

130 Silverman, Case Comment, Applebaum v Board of Directors of Barton Memorial Hospital, Hospital Privileges Proceedings—the Law is Clear. If only it were Applied in Applebaum, L.A. Daily J., Jul 11, 1980.

131 104 Cal App 3d 653, 163 Cal. Rptr. 831 (1980)

acted favorably on this recommendation prompting Dr. Applebaum to request review by the medical staff appeals committee. This committee was comprised of three physicians who had not previously been involved in the dispute. After considering the available information the appeals committee agreed that Dr. Applebaum's privileges be suspended.[132]

These facts, if considered under the principles thus far discussed, would not seem to require that the hospital's decision be overturned. In fact, this may be an easy case under those precepts since ultimately there was no overlap of investigatory and final adjudicatory function and none of the members of the appeals committee had previous involvement in the case. (Two of the appeals committee members had been appointed to the executive committee after it had reached its decision but other than having heard some unspecified disparaging remarks, there was nothing to connect these physicians with Dr. Applebaum's case. Hearing such remarks would seem clearly to fall within the rule that general awareness of the subject is not a disqualifier).

The California Court of Appeals did not view the facts that way however. Quoting from the opinion

> The distinction between fair procedure and due process rights appears to be one of origin and not of the extent of protection afforded an individual...Biased decision makers are constitutionally impermissible and even the probability of unfairness is to be avoided...The question before us is whether this situation, completely apart from any question of actual bias on the part of any of the physicians involved and from the merits of the charges, presents a violation of fair procedure rights to an impartial tribunal by virtue of a practical probability of unfairness. We hold it does. As a practical matter and without in any way impugning their good faith, the general practitioner and pediatric specialist members of the ad hoc committee were in an extremely difficult position. The charges were brought by one of the two specialists on whom they were accustomed and, indeed required to rely for obstetrical expertise and with whom they were in frequent and intimate professional contact. His associate supported the charges and the committee was thus presented with a solid front of the only

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[132] Id at 836

> special expertise available to it. To presume impartiality of the ad hoc committee in such circumstances goes beyond what can reasonably be expected of human beings in this professional setting...We recognize that the ad hoc committee's function...was nominally investigatory not adjudicative. Nevertheless, the chances of a contradictory conclusion by another body within the hospital were virtually nil.[133]

Does this decision mean, as has been commented, that it is necessary to have medical staffs of sufficient size so that at each stage of an evaluation there will be no prior involvement of reviewing physicians and preferably no prior knowledge of the individual under investigation?[134] Since that is an untenable result, one is left with no conclusion other than, as subsequent decisions indicate,[135] Applebaum doesn't mean what it seems to say and despite the fact that the California Supreme Court refused to consider Applebaum, Anton continues as the law in California. The situation certainly bears further watching.

In the meantime, the safest course for all facilities is to adopt bylaws which separate the investigative and adjudicative function to the extent possible and to ensure that individuals responsible for initiating and conducting investigations are not a part of the decision making process.

Procedures which combine prosecutorial and adjudicative functions pose additional problems. Where, for example, a member of the hearing committee takes an active role against a physician such as offering personal statements against him or her, a reviewing court would probably view this as an improper

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133 Id. at 836

134 Silberman, supra note 130

135 Miller v National Medical Center, 124 Cal. App. 2d 91, 177 Cal. Rptr. 110 (1981), Smith v Vallejo General Hosp., 170 Cal. App. 3d 453, 216 Cal. Rptr. 189 (1985)

combination of the prosecutorial and adjudicatory function and find a violation of due process.[136] Any committee member who is to be a witness against the physician or is otherwise actively involved in prosecuting the charges should therefore be disqualified from sitting on the hearing panel.

Guideline 4: The role of counsel at the hearing should be specifically defined in the medical staff bylaws. This role should allow for the presence, though not necessarily the active participation, of counsel.

In New Jersey, a physician has the right to have counsel present at mandated hospital hearings convened to consider an application for admission to the staff.[137] This is the only jurisdiction which has expressed such a right (though there is some authority that when hospital counsel is to be present at the hearing the physician should also be entitled to have counsel in attendance.[138] But while presence of counsel is to be allowed, New Jersey retreats to more familiar ground when it describes the role of counsel. The attorney's participation and role "will be subject to the reasonable rules laid down by the hospital's board of trustees or other authorized persons and management and control of the hearings will rest with the person or persons in charge."[139]

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136 Hoberman v Lock Haven Hosp., 377 F. Supp. 1178 (M.D. Pa. 1974), citing, Wasson v Trowbridge, 382 F. 2d 807 (2d Cir. 1967)

137 Garrow, 401 A. 2d at 542 (The California Court of Appeals, in an unpublished decision, has only recently restated the widely held position that physicians in that jurisdiction are not entitled to counsel at hearings to determine whether privileges will be granted. Patwardham v San Antonio Community Hospital, (Calif Ct. App. 4th Dist. Oct 22, 1985), petition for cert. filed, 54 U.S.L.W. 3829 (U.S. May 13, 1986)(No. 85-1931)

138 Silver, 497 P. 2d at 572

139 Garrow, 401 A. 2d at 542. See, Anton, 567 P. 2d at 1176; Silver, 497 P. 2d at 572

The discretion vested in the hearing committee is generally extended in other jurisdictions to the question of whether the physician will be permitted to be represented by counsel at the hearing. This is a common and arguably dangerous practice. Surely the purpose of such discretion is to give the committee power to ensure that the hearing does not become embroiled in an adversary environment where form overtakes substance. As one writer put it in his recommendation that the hearing officer hold a pre-hearing conference with counsel for the physician and counsel for the medical staff:

> Preliminarily, the hearing officer can gain a feeling of the nature of the two attorneys...he can determine — and granted this is subjective — whether the two counsel are interested in having a true hearing to arrive at what is fair or whether they are simply going to make this a showpiece for their own talent or, in some cases,lack thereof.[140]

While the goal is a worthy one, the means are questionable. Under this practice the opportunity for a physician to be represented by counsel turns less on what is fair and more on the personality of counsel. If an attorney comes on hard early and tries to discourage a credentials action by legitimate, though intimidating methods, he or she may find the hearing room door closed by committee members seeking to show the lawyer whose hospital it really is or simply because the members don't want to confront the tough lawyer. The specter of arbitrary and unequal treatment of physicians at credentials hearings is raised by this discretionary power. Granted, the adversary nature of the proceeding, and it is adversary, can and should be minimized. But a placid, passive physician who will not or cannot aggressively defend him or herself deserves the same exacting scrutiny of charges as the wily old buzzard who isn't going to let anyone push him around.

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[140] Ginsberg and Diller, Medical Staff Hearings and Questions of Due Process, Right to Counsel and Liability, 2 Whittier L. Rev. 684 490 (1980)

New Jersey has taken a step in the right direction in recognizing that presence does not equal vocal participation. An attorney sitting at the arm of the client can probe and protect the clinician's interest through the client himself or herself. Objectionable procedural points can be raised by the clinician at the prompting of counsel though most major matters of process could and should be raised and resolved if possible during a pre-conference hearing. The difficult questions and the critical follow-up inquiries can be directed so that relevant information is not overlooked. Certainly this side-stage dialogue could lengthen the time required to complete the hearing but such delays would not likely be overtaxing and when weighed against the clinician's need for objective guidance in a difficult and perhaps complex inquiry, it is more than compensated for by its salutory effect on the process. The committee, through the hearing officer, (see Guideline 5 infra) still controls the flow of the proceedings and through appropriate bylaw construction counsel who cannot abide by the role prescribed can be excluded.

Guideline 5: The bylaws should require that the hearing officer be responsible for the conduct of the hearing and its process. The hearing officer should be an impartial individual, functioning as a Parliamentarian and preferably should have legal training.

There is no great body of law to discuss in conjunction with this rcommendation though it has been favorably commented upon by at least two courts.[141] The guiding principles come from the basic requirements of due process. A credentials hearing is an emotional process for clinician and committee. An objective voice is needed. While a previously uninvolved administrator or clinician could serve ~~in the role~~ as hearing officer, one cannot ignore the

[141] Klinge, 523 F. 2d at 62; Woodbury, 447 F. 2d 839

increasing part played by the use of threatened use of litigation. Someone with no party affiliation and with a knowledge of the law's requirements should oversee the process and ensure that the rules of fairness are being met by the committee and not being abused by the practitioner. The hearing officer's primary role is to ensure that all persons involved are aware of the procedural rules and that those rules are followed. He or she should not participate in deliberations except to answer procedural questions which arise.

Guidelines 6: Information concerning the basis of adverse action should be presented by an individual who is not associated with any committee having an investigatory or adjudicatory role in the proceedings. This individual should present all available relevant information, including that favorable to the subject physician.

The hearing officer should not be tasked with presenting the substantive information to the committee. That role should be assigned to someone outside the investigative or adjudicative process.[142] This person should understand that his or her function is not to "beat" the physician but only to ensure that all information is presented to the committee in an orderly fashion. While this individual could be the hospital attorney,[143] the better procedure would be to have a clinician, familiar with the practice of the subject physician if possible, marshall the material. Assistance in preparing the evidence could certainly be provided by hospital counsel and the hospital counsel could attend the hearing in the same non-speaking role as counsel for the physician.

Guideline 7: The party with the burden of proof should be identified in the bylaws.

142 See, Note 35 and accompanying text

143 Koelling v Board of Trustees of Mary Frances Skiff Mem. Hosp., 146 N.W. 2d 284 (Id. 1966); Woodbury, 447 F. 2d 839; LLadenheim, 394 N.E. 2d 770

Is it incumbent upon the medical staff to show that a recommended adverse action is correct and supported by adequate evidence or is it the initial responsibility of the physician to show that the action is incorrect, unreasoanble, arbitrary or capricious? Bylaws placing the burden on the physician have been ruled valid by the courts deciding the issue,[144] therefore the decision of where the burden will lie is left to the facility. The hospital bylaws should clearly specify who has this burden so that the parties understand their respective responsibilities.

Guideline 8: The physician must be given a meaningful opportunity to be heard, including the right to present information and question available witnesses.

The hearing should fairly search for the truth underlying the charges. The physician must be given reasonable opportunity to present any evidence he or she has to rebut or explain matters before the committee and the opportunity to explore and expose possible bias or prejudice of witnesses. However there is no requirement that the hearings adhere to rules of evidence.[145]

Due process does not require that the review committee personally examine any patients whose treatment is suspect.[146] Since there is no subpoena power in this administrative hearing the courts have recognized the impracticality of recognizing a right to confront and cross examine witnesses. The diffiulty lies in that it may not be possible to persuade witnesses to testify if they know that they will be subject to cross examination. Even if they do testify, there is nothing to stop them from leaving before any cross examination

144 Bock, 702 P.2d 253; Woodbury, 447 F.2d 839

145 See, Christhilf, 496 F.2d 174, Klinge, 523 F. 2d at 62; Koelling, 146 N.W.2d at 288; Silver, at 572

146 See, Kaplan v Carney, 404 F. Supp 161 (E.D.Mo. 1975)

begins.[147] This may be a special problem where a patient has alleged that the physician made improper sexual advances.

Despite these limitations, every effort should be made to ensure that the physician has the chance to present all relevant information, documentary and testimonial, direct and cross examination.

Guideline 9: The bylaws should provide authority to allow a physician to be summarily suspended whenever action must be taken immediately to protect patient care.

The language of the above guideline is taken from the Joint Commission on Accreditation of Hospitals standards.[148] The protection of human health and life is a valid governmental and medical interest that permits summary action preceding a hearing.[149] Summary action based on such considerations is acceptable provided that the physician is afforded a hearing within a reasonable period.[150] Because it is likely that privilege restrictions will have an immediate, detrimental financial and/or professional impact on a health care provider, the summary suspension procedure should only be used when harm to the public is threatened. An example of the improper application of the sumary procedure is Storrs v Lutheran Hospitals[151] where a physician's summary suspension was overturned because it was based on a charge of disruptiveness or inability to work with others with no related charge concerning medical competence.

147 Denial of Hospital Staff Privileges: Hearing and Judicial Review, Supra, note 68

148 Joint Commission of Accreditation Manual, (1985 Ed.)

149 Richards, 603 F. Supp. at 84

150 Citta, 313 F. Supp. 301

151 Richards, 603 F. Supp. at 84

Conclusion

Hospitals cannot balance and fulfill their responsibilities to the public and their staff physicians without a well defined credentialing program. This process needs to include a system of selecting, monitoring and evaluating staff physicians. When it reveals a physician of questionable qualification or one who exhibits suspect performance or behavior, the process must allow prompt, decisive and fair action. With an almost endless variety of possible circumstances, problems and personalities, a hospital must have a well conceived, objective fair hearing plan to meet this demand.

Whether or not a hospital agrees with the specifics of the guidlines presented here, it is necessary to incorporate their underlying policies and legal principles into the fair hearing plan. The identity and role of the hearing officer, for example, can be prescribed in many legitmate and acceptable ways. But if the hospital, through the hearing officer, creates a hearing environment in which the provider is placed at a serious disadvantage (such as where the hearing officer is a legally trained advocate for the hospital) then the hospital may expect serious judicial challenge to adverse credentials decisions.

In short, hospitals can no longer assume that their staffing decisions are "in house." While deference to professional judgment still exists, courts are becoming less reluctant to critically scrutinize the procedure and substance of peer review. There are many reasons, legal, economic and professional for implementing a fair hearing plan. If there are good reasons to ignore the increasing pressure for such a plan they are quickly disappearing under the layers of recent court decisions.

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Hospital credentials action and due process: a framework for fairness